

CHANGE REPORT

CASE NAME	CASE NUMBER
WORKER NAME	LOCALITY
AGENCY TELEPHONE NUMBER	

Use this form or call your worker to report changes listed below for your Food Stamps or Temporary Assistance for Needy Families (TANF) case.

Report changes within 10 days of the day they occur; but at the latest, you have until the 10th day of the following month to report the change.

Note: If you have a Medicaid case, you must report **all** changes to your Medicaid worker within 10 days.

ADDRESS CHANGE

New Address (Street, Apt. Number)	City, State Zip	Telephone
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GROSS INCOME FOR YOUR HOUSEHOLD GOES OVER THE LIMIT BELOW

Number of People in your Household	Monthly	Weekly	Every 2 weeks	Twice a month
1	\$1,037	\$241.16	\$ 482.32	\$ 518.50
2	1,390	323.25	646.51	695.00
3	1,744	405.58	811.16	872.00
4	2,097	487.67	975.34	1,048.50
5	2,450	569.76	1,139.53	1,225.00
6	2,803	651.86	1,303.72	1,401.50
7	3,156	733.95	1,467.90	1,578.00
8	3,509	816.04	1,632.09	1,754.50
For each additional member add	+ \$354	+ \$82.32	+ \$164.65	+ \$177.00

These amounts are good through 9/30/06.

Add gross income for all the people in your household. New income total \$ _____

THE NUMBER OF WORK HOURS IN A WEEK GOES UNDER 20 FOR MEMBERS WHO ARE 18-50 IF THERE ARE NO CHILDREN IN THE HOUSE

NAME	NUMBER OF HOURS	WHERE WORKING
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IF YOU RECEIVE TANF, TELL US IF AN ELIGIBLE CHILD LEAVES YOUR HOME

Name	Date moved out	Name	Date moved out
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CHANGES THAT MAY AFFECT VIEW PARTICIPATION FOR TANF. DISCUSS WITH YOUR VIEW WORKER.

Change that has occurred _____

CHANGES YOU MAY WANT TO REPORT

CHANGE IN SHELTER EXPENSES

Rent or Mortgage	Property Taxes	Homeowner's Insurance	Electricity
\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
Gas	Oil	Kerosene, Coal, wood, etc. List and give amount	
\$ _____ per _____	\$ _____ per _____		
Water/Sewer	Garbage	Telephone (Basic Service Only)	Installation Fees
\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____

CHANGE IN DAY CARE EXPENSES

Person paying for care	Person receiving care	Amount billed	How often?
		\$ _____	

CHANGE IN MEDICAL EXPENSES FOR MEMBER WHO ARE 60 OR MORE OR DISABLED

Name	Type of expense	Amount billed
		\$ _____

CHANGE IN LEGALLY OBLIGATED CHILD SUPPORT PAID TO ANOTHER HOUSEHOLD

Person paying support	Person receiving support	Amount legally obligated	Amount paid
		\$ _____ per _____	\$ _____ per _____

CHANGE IN THE NUMBER OF PEOPLE IN YOUR HOUSEHOLD

Has ANYONE MOVED IN?

Name	Date moved in	Relationship to you	Social Security Number	
Date of Birth		Race (not required)	Sex	Marital Status
U.S. Citizen Yes () No ()	If Alien, give alien number, date of entry	Last school grade completed	Currently in School? Yes () No ()	

HAS ANYONE MOVED OUT?:

Name	Date moved out	Name	Date moved out

HOW LONG DO YOU EXPECT THE CHANGE(S) TO CONTINUE

() YES () NO Do you expect any of the change(s) you listed on this report to continue beyond this month? If YES, explain

I declare that all information I gave on this form is correct and complete to the best of my knowledge and belief.

Signature _____ Date _____

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